

Naval Helicopter Association 2008



Safety Symposium RADM A.J. Johnson "Blackjack"





The Agenda: An Overview

- NSC's Mission Statement
- USN/USMC Mishap Rates
- CFIT
- White Out/Brown Out
- Aviation Trends and Takeaways
- · ORM
- Tools and Resources





"Change is the mother of all risk"





NSC MISSION STATEMENT

Naval Safety Center provides safety assistance and advice to the CNO, CMC, and the Deputy Assistant SECNAV (Safety) to enable mishap prevention & save lives in order to:

- -enhance warfighting capability
 - -preserve resources and
 - -improve combat readiness





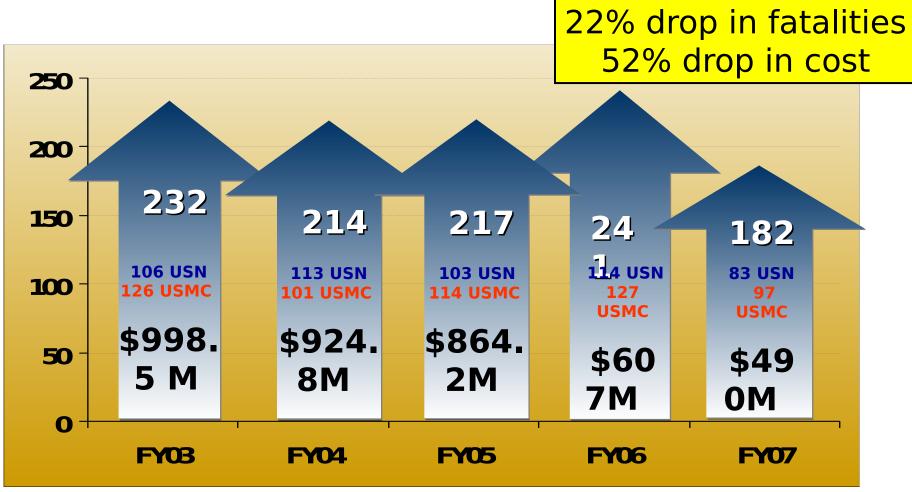
NHA Symposium Apr 14-17 2008







DON Mishap Trends







NUMBER OF FATALITIES



FY07 vs. FY03:

SECRETARY OF DEFENSE CHALLENGE



THE SECRETARY OF DEFENSE 1000 DEFENSE PENTAGON

MAY 3 0 2007

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS CHAIRMAN OF THE JOINT CHIEFS OF STAPE UNDER SECRETARIES OF DEFENSE ASSISTANT SECRETARIES OF DEFENSE GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE DIRECTOR, OPERATIONAL TEST AND EVALUATION INSPECTOR GENERAL OF THE DEPARTMENT OF DEFENSE ASSISTANTS TO THE SECRETARY OF DEFENSE DIRECTOR, ADMINISTRATION AND MANAGEMENT DIRECTOR, PROGRAM ANALYSIS AND EVALUATION DIRECTOR, NET ASSESSMENT DIRECTORS OF THE DEFENSE AGENCIES DIRECTORS OF THE DOD FIELD ACTIVITIES

SUBJECT: Zero Preventable Accidents

I am committed to reducing preventable accidents as one of the cornerstones of the Department of Defense's Safety Program. Consistent with the President's Safety, Health. and Return-To-Employment (SHARE) initiative, I have set some very specific mishap reduction goals for the Department. We are focused on closely monitoring our most pressing mishap areas: civilian and military injuries, aviation accidents, and the number one noncombat killer of our military, private motor vehicle accidents.

We can no longer tolerate the injuries, costs, and capability losses from preventable accidents. Accidents cost the Department about \$3 billion per year, with indirect costs up to four times that amount. We have made progress in reducing aviation accidents and civilian lost work days, but have much more to do to address military injuries and private motor vehicle fatalities. Our goal is zero preventable accidents, and I remain fully committed to achieving the 75% accident reduction target in 2008.

The current focus of our Safety Council is on increasing the accountability of individuals and leaders, as well as pursuing safety technologies. Accountability and leadership are key to an effective safety program. I urge you to continue to emphasize safety in the workplace and hold leaders accountable for their safety programs. Your efforts will make the Department a safer place to work, and more capable of defending the Nation and her interests. We have no greater responsibility than to take care of those who volunteer to

We can no longer tolerate the injuries, costs, and capabilities losses from

Memorandum from Secretary of Defense, 30 May 2007





Bad Day



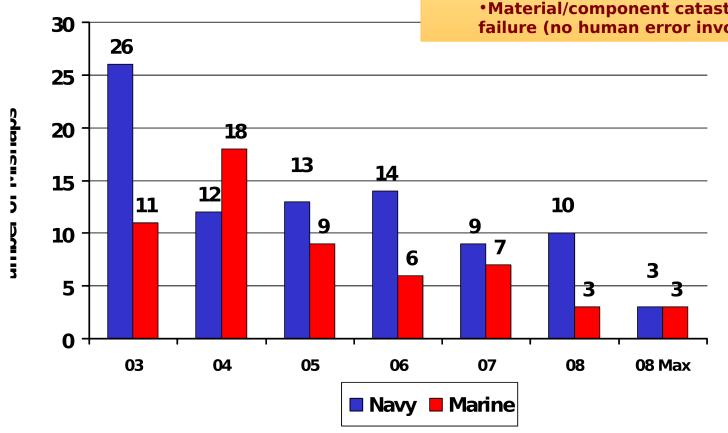




Class A Flight Mishaps

Causal Factors

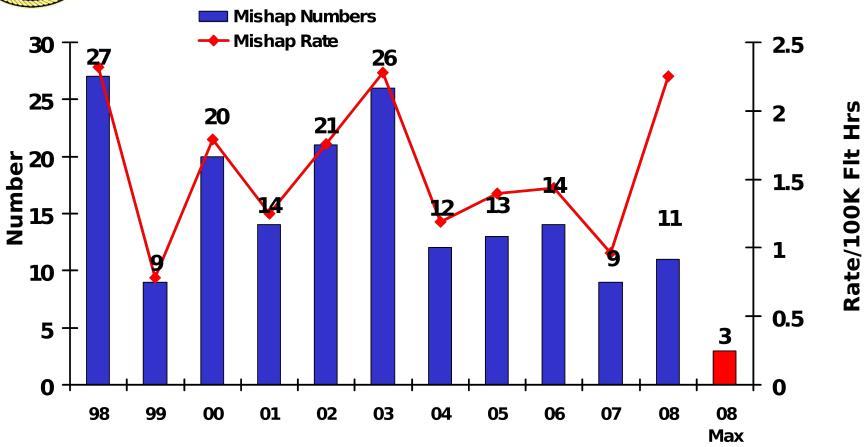
- Human Error (90%: 55% are HE alone)
 - Aircrew (breakdown in Crew Resource) Management, poor decision making, failure to properly perform emergency procedures)
 - Supervisory (failure to provide adequate guidance and training)
- Material/Systems Malfunction (10%)
 - Material/component catastrophic failure (no human error involved)







USN CLASS A FLIGHT

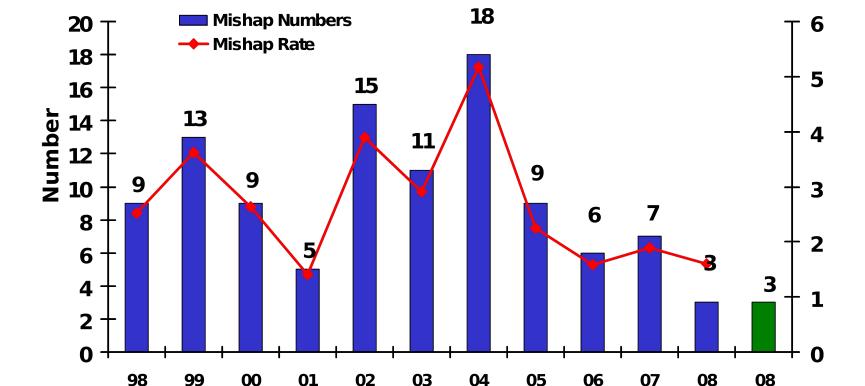








USMC CLASS A FLIGHT



Rate/100K FLT HRS

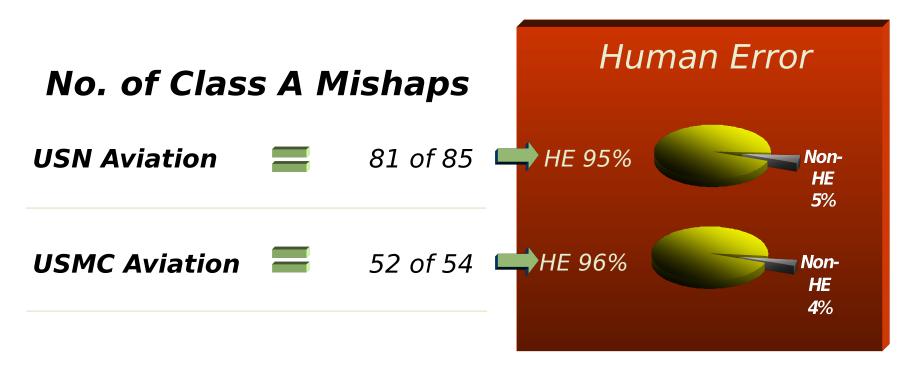




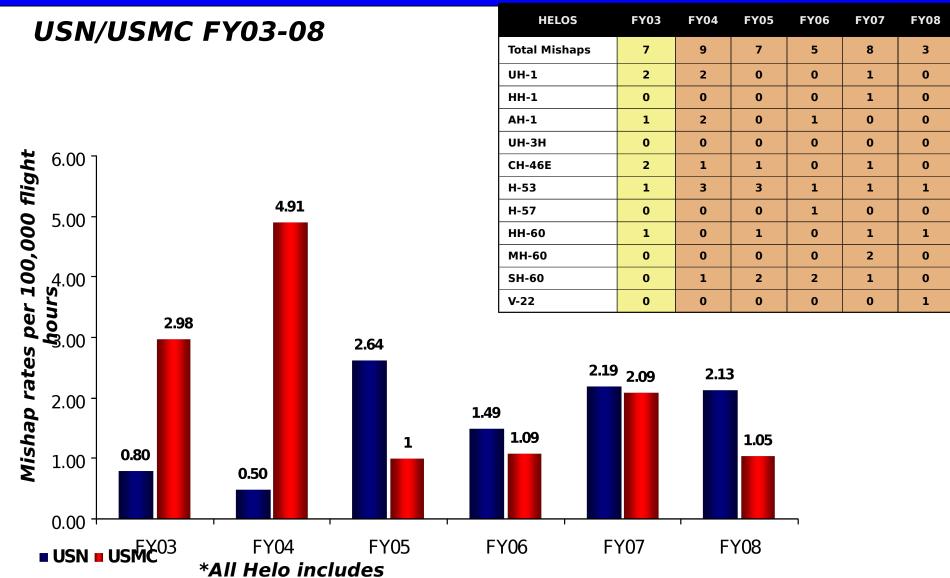
Max

Human Error

USN/USMC, FY03-07

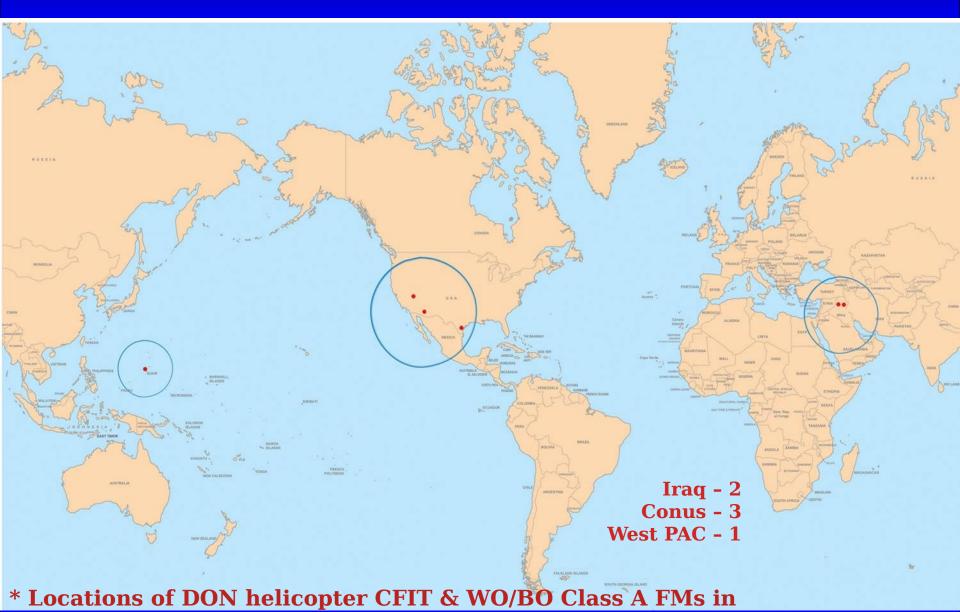


Helicopter Historical Class A FM Mishap Rates





WHAT DO THESE RED DOTS HAVE IN COMMON?



DEFINITION OF A CFIT

 Collision with terrain, water, trees or a man-made obstacle during flight prior to planned touchdown.

Note: This does not include the landing or take off phase of flight.





DEFINITION OF A WO/BO Mishap



 Mishaps involving helicopters, tiltrotors and vertical takeoff & landing aircraft/UAV resulting from encounters with whiteout or brownout conditions (visually degraded environment) during takeoff or landing

In the Dust





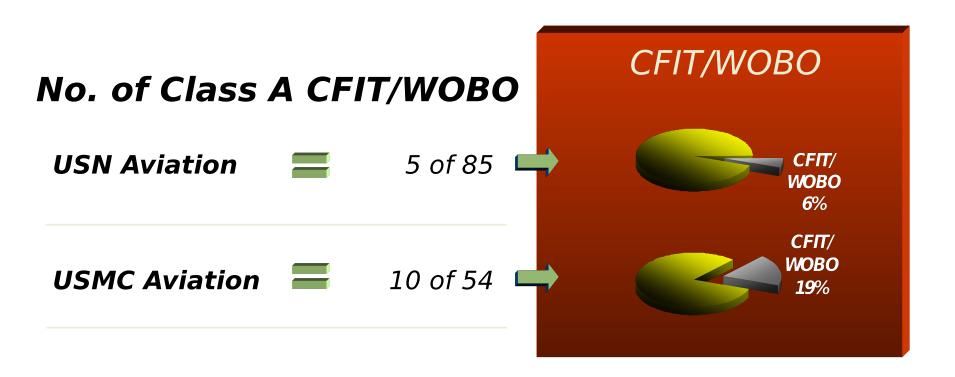




- •LOOKING out the cockpit of a 46 after a desert landing
- •Dash-1 is out there

CONTROLLED FLIGHT INTO TERRAIN (CFIT) WHITEOUT / BROWNOUT (WO/BO)

USN/USMC, FY03-07



CFIT & WO/BO

• FY 07

- Five of Eight helo Class
 A FM events were
 CFIT/WOBO (63%)
- <u>3</u> USN / <u>2</u> USMC
- FY 08
 - One of Three helo
 Class A FM events
 were CFIT/WOBO (33%)
 - <u>1</u> USN



Navy CFIT & WO/BO

- FY 07
 - 7 MAY 07 SH-60F Struck power lines (CFIT)
 - 10 AUG 07 HH-60H
 Tail rotor struck
 building during
 troop insertion
 (WOBO)
 - 24 SEP 07 MH-60S
 Tail rotor struck
 tree during SAR
 training (CFIT)
- FY 08
 - 16 JAN 08 MH-53E
 Struck tower in IMC
 conditions (CFIT)





Marine Corps CFIT & WO/BO



• FY 07

- 11 DEC 06 CH-53E,
 Impacted ground and rollover, Day
 Training, (WOBO)
- 16 AUG 07 HH-1N,
 Struck Cliff, Day
 Training (CFIT)
- FY08
 - None to date





RED THREAT VS. BLUE THREAT

- Every DON helicopter mishap in FY 07 and FY 08 so far has been a result of the BLUE threat NOT direct enemy action (DEA).
- The cost in dollars and lives is unnecessary and unacceptable!





Aviation Trends and Takeaways

TRENDS

Mishap Investigations

- Human error (aircrew):Causal factors
 - Skill-based errors
 - Decision errors

Preconditions for errors

- CRM failures
- Adverse mental states
- Inexperience
- Training issues

TAKEAWAYS

- Adherence to basic rules, regulations and NATOPS procedures
- Proper pre- flight planning
- Training
- Proficiency
- Institutionalize ORM & CRM
- Enforce standards
- Increase checks and

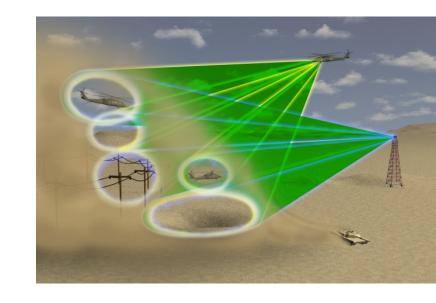






A Way Ahead

- Currently all services are exploring technological solutions
- Plan is to provide onboard equipment that will:
 - "See" through the obscuration
 - Provide cockpit
 instrumentation to allow
 landing from a hover or
 with slow forward airspeed



DOD/Service Brownout Mitigation Initiatives

OBJECTIVE: PRESERVE COMBAT CAPABILITY BY REDUCING LOSSES DUE TO BROWNOUT

Near-Term Materiel Solutions

- Sandblaste
- LandSafe Progra
- Helicopter Autonomous Landing System (HALS III)
- Improved Altitud Hold and Hover (I-AHHS)
- Electronic Bumper
- 3-D Laser Radar











ORM - A systematic process, not a program

3 Levels

In Depth

Long term process with extensive research and planning

Deliberate

Pre-mission planning, time available for planning, recorded on paper.

Time Critical

5. Supervise Little time, done on the run, applied to control hazards introduced by unexpected events and changes to the plan.

4 Principles

- ✓ Accept no unnecessary risk.
- ✓ Anticipate and manage risk by planning.
- ✓ Make risk decisions at the right level.
- ✓ Accept risks when benefits outweigh the costs.

5 Steps

1. Identify. Hazards

> 2. Assess **Hazards**

4. Implement **Controls**

3. Make Risk **Decisions**





Reaching the War Fighter



Threat Losses (FY Jan '91-07)

Red Threat - 18 Aircraft Destroyed VS.

Blue Threat - 542 Aircraft Destroyed

The Blue Threat

Puts the concepts in to terms the War Fighter understands

Hazards = Threats

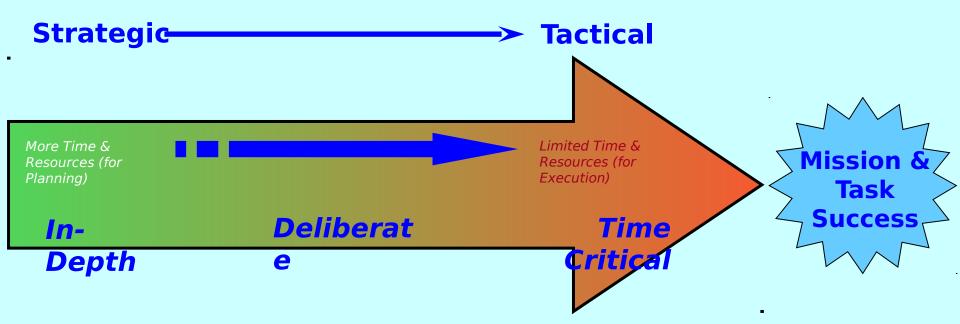
ORM = Tactics

CRM = **Skills**





Risk & Resource Management Big Picture



Controls from one level become resources



ORM is about understanding the potential consequences of your



- Degradation of combat readiness
- > Impact on mission accomplishment
- > Impact on the Team, Family and Fr



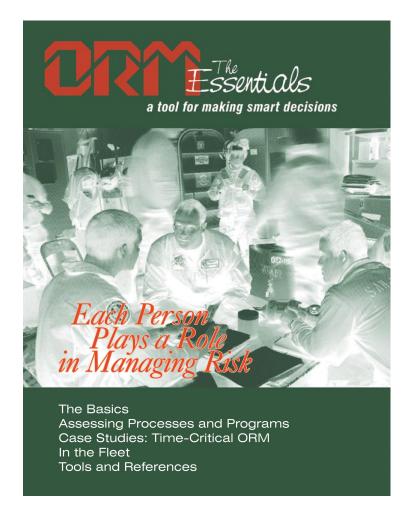








ORM Summary



- A systematic process to assist in making informed risk decisions
- Should be integrated into your command planning, briefing, execution and after action processes
- Relies on education, training, experience and teamwork
- Requires outstanding communication skills at all levels
- Requires a environment where hazards can be identified by anyone at any time



Not a member of NHA...

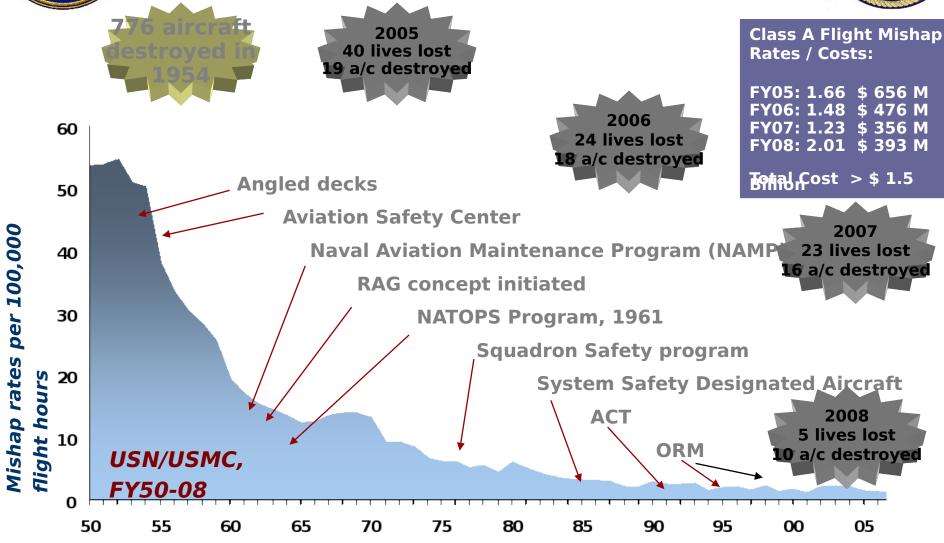






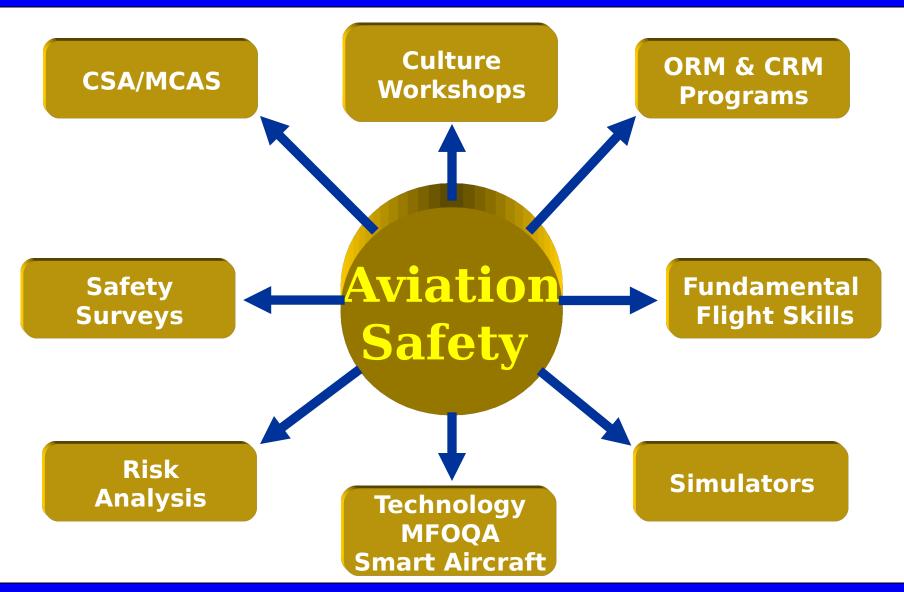
What We Have Done to Reduce Mishaps







Aviation Intervention Strategies









NSC Web Site





www.safetycenter. navy.mil



* Chand-Dawn (ODM for

NAVSAFECEN "SAVES" of the Year



4 29 October 2007:

- -LT Barnet Harris , HT-28
 - -Student inadvertently secured the engine.
 - -LT Harris immediately executed a successful engine restart at 75 feet.

9 November 2007:

-LT Kelly Natter, LT Scott Cohick, AW1 Robert Johnson, AW2 Patrick Baumia and AW2 Jonathon Reese, HS-2

- -Aircraft experienced a catastrophic tail rotor malfunction at the end of a long mission & 25nm from the ship.
- -LT Natter executed an autorotation into the water at night on goggles in low light conditions.
- ⁻All crew and passengers egressed safely with only minor injuries. **2 February 2008:**

-LT Theodore Lemerande, HT-28

- -Single engine TH-57C helicopter lost all engine power at 500 feet, just after take-off.
- -LT Lemerande executed a successful 180 degree autorotation back to the airport avoiding an airliner on take-off with a textbook power-off landing. **25 February 2008:**

-LT John McKenzie HT-28

-Singel engine TH57C heilcopter lost all engine power at night at approximately 10 feet AGL.

He executed the appropriate EPs to land the aircraft without further













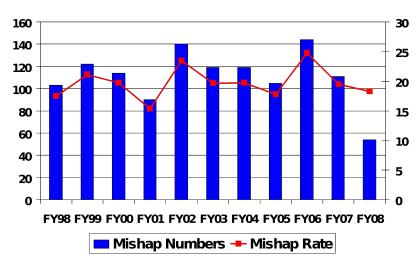


Back-Up Slides

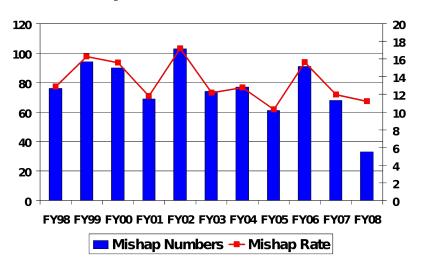




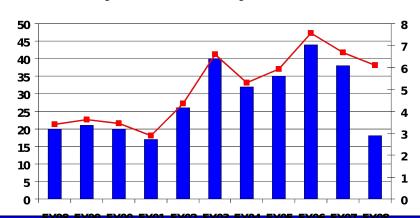
Navy/Marine PMV Fatalities



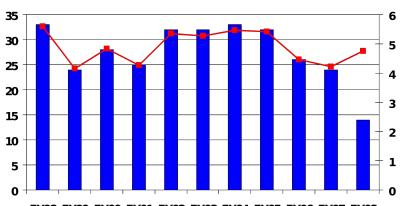
Navy/Marine 4-Wheel Fatalities



Navy/Marine Motorcycle Fatalities



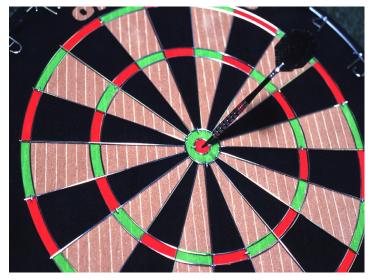
Navy/Marine Off-duty/rec Fatalities







ORM: A Tool For Leaders



Five Steps

1. Identify
Hazards

5. Supervise

2. Assess
Hazards

4. Implement
Controls

3. Make Risk
Decisions

- Easy, common-sense process
- Mind-set
- Way of life On- and Off-Duty
- Operating discipline
- Process must be taught
- Must institutionalize ORM

YOU CAN'T "ORM" SOMETHING THAT'S STUPID, TO SOMETHING THAT'S SMART!!!

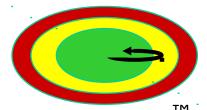


Time Critical Risk Management Elements

Process and Mnemonic

- Assess (your situation, your potential for error)
- B Balance Resources (to prevent and trap errors)
- C Communicate (risks and intentions)
- D Do & Debrief (take action and monitor for change)

Risk Assessment



- Green: Errors may occur, but they will be caught
- Yellow: Errors may occur, but they may not be caught and may become cumulative
- Pod Errore will occur that are not caught

<u>Crew Coordination</u> <u>Skills</u>

- Situational Awareness
- I know my environment
- I can see changes
- Mission Analysis
- I can assess the changes
- I can see how they affect my job/mission
- Adaptability/Flexibil ity
- The plan is flexible and we can adapt to changes
- Decision Making
- We have enough information, time and a good plan of action, or we need help
- Assertiveness
 - I have confidence in myself, my team, and my leadership to bring new threats to their attention
- Communication
 - I need to let my teammates or others involved know what I know
- Leadership

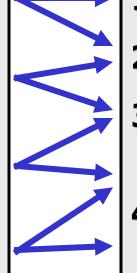
Time Critical and Deliberate

<u>Time Critical</u> <u>Process and</u> <u>Mnemonic</u>

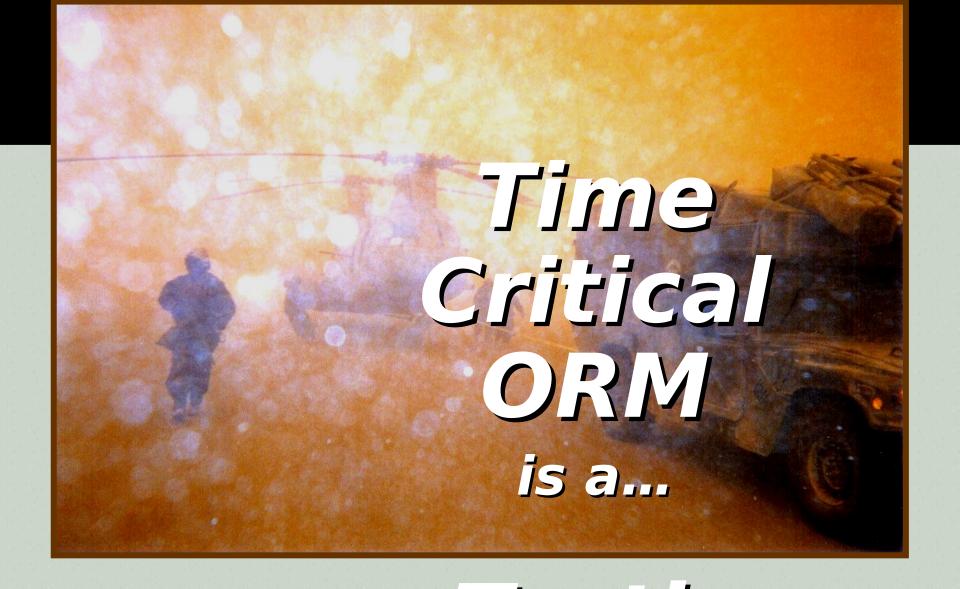
- A Assess (your situation, your potential for error)
- **B** Balance Resources (to prevent and trap errors)
- C Communicate (risks and intentions)
- D Do and Debrief (take action and monitor for change)



- 1. Identify Hazards
- 2. Assess Hazards
- 3. Make Risk Decisions
- 4. Implement Controls
- 5. Supervise (watch for changes)







Blue Threat - Action/Inacti r 3 6 Causing losses

Blue Threat - Losses far exceed Red Threat losses